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LONG-TERM CARE: FROM HOUSING AND HEALTH TO HUMAN SERVICES

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BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

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LONG-TERM CARE: FROM HOUSING AND HEALTH TO HUMAN SERVICES

TUESDAY, JANUARY 5, 1988

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Minneapolis, MN.

The committee met, pursuant to notice, at the Augustana Homes/Park Center Apartments, Minneapolis, MN.

Present: Senator Durenberger.

Also present: Mary C. Edwards, legislative assistant.

OPENING STATEMENT BY SENATOR DURENBERGER

Senator DURENBERGER. Good morning everyone. I am very pleased to call to order this official field hearing of the U.S. Senate Special Committee on Aging.

This is the first of 12 hearings and forums which will be held around the State of Minnesota over the next 5 days as part of this field hearing, all of them dealing with the broad subject of long-term care. The forums have been set up with the cooperation of the State's area agencies on aging, God's gift to policy making, I'll tell you. In this case, it's the Metropolitan Council of the Twin Cities area.

The Council was among the first government agencies in Minnesota to recognize the importance of long-term care issues ranging from housing and health to human services.

So I want to begin by thanking the Council's chair, Steve Keefe, and the Council's staff for their assistance in setting up today's hearing. In effect, they are cochairing this hearing with the Senate Special Committee on Aging.

I also want to thank our host today, Park Center Apartments, for generously lending us this facility, particularily, Tim Tucker the person who has the responsibility for making all of this work, and Larae Canadarude—the area agency director.

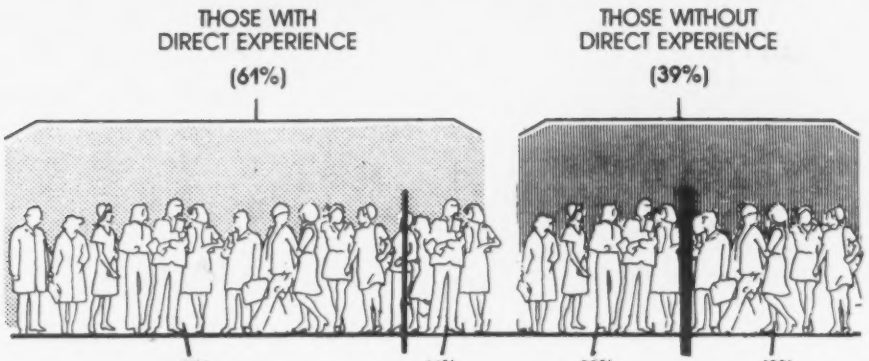
The purpose of these hearings is to tap the experience and the best minds of a State which is known nationally as a leader on health care issues including long-term care. Our witnesses today will help define this State's and this community's long-term care problems, and their testimony will then help me and the other members of the committee in drafting legislative solutions.

Long-term care is not a subject just for the so-called experts who we're going to be calling on today. A recent survey done for the American Association of Retired Persons, of which I am a member, summarized on this chart, found that four out of five Americans

have had or expect to have some experience with long-term care. Eighty-one percent of everyone in this country knows something about what we're talking about today.

CHART A

81 PERCENT OF AMERICANS HAVE HAD – – OR EXPECT TO HAVE – – DIRECT EXPERIENCE WITH LONG TERM CARE



Source: National Poll conducted by RL Associates for AARP and the Villers Foundation, July 1986.

So this is clearly not an issue just for my parents' generation, although I want to tell you George and Isabelle, my folks, worry every day about what happens if one or the other of them has to go into a nursing home. I spent Christmas with my parents and then all morning the next day talking about what's the next step in their life.

They assume that they are going to have to sell their home quite soon. My dad's eyesight is failing him to the point where I can't give him books for Christmas anymore because he can't read them, and he's got a little recording machine in his bedroom where he can sit and listen to famous books on recordings. They just assume that the next step is something other than owning their own home, but they don't know what, and we spent a morning talking about that.

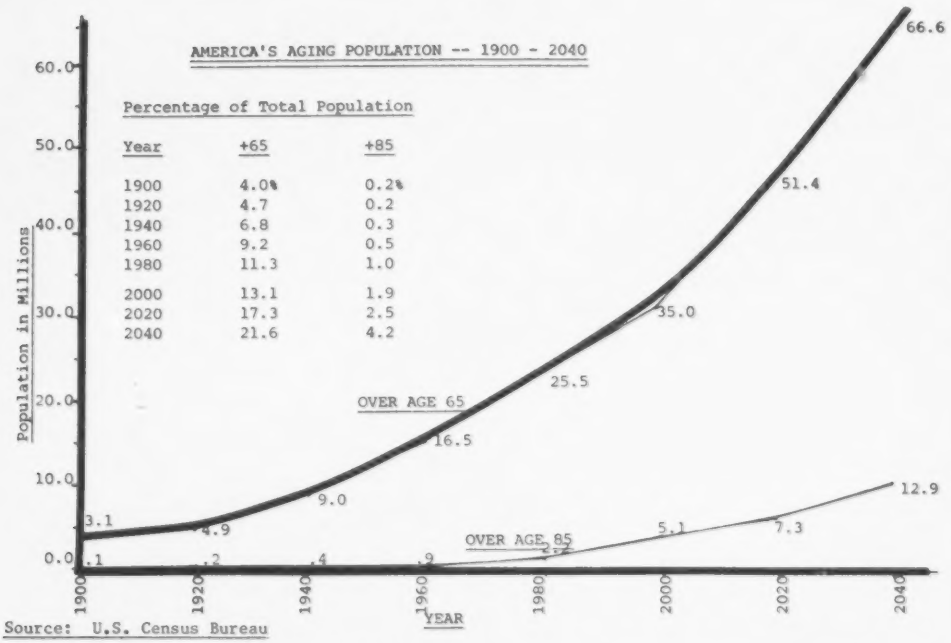
Institutional care, nursing home care, in particular, in America today costs $20,000 to $30,000 a year, and you can imagine the life savings that can be consumed very quickly in meeting that kind of care at those kinds of costs.

Long-term care is not an issue just for my generation either, for the children of the people who today need long-term care, although the children of today's elderly are among those immediately affected by decisions made by and for our parents.

And long-term care is not just an issue for my son's generation, although they have the most to gain or lose from decisions that we are starting to make now about long-term care.

The second chart, entitled "America's Aging Population," shows why long-term care must be thought about in the context of both present and future generations of elderly.

CHART B



Source: U.S. Census Bureau

The top line shows the rising number of Americans over the age of 65, from 3.1 million in 1900 to 25½ million in 1980; and it's projected to rise, on the right-hand side of that chart, to over 66 million of us in the year 2040. 2040 just happens to be the year that my youngest son, Danny, will be as old as my father is today. That's where it will come, 16 million people in 1960, 25 million people today, 66½ million people by the time my son needs this kind of care.

The bottom line tells an even more dramatic and important story. It shows the growing number of Americans over the age of 85. These are the people most likely to become frail. These are the people that we visited in the nursing home. These people need some kind of permanent long-term care.

In 1900, by this estimate by the Bureau of the Census, there were only 100,000 people in America over the age of 85; in the whole of the country, only 100,000 people. In 1980 there were 2.2 million people. In the year 2040, out on the right-hand side of this chart again, about the time my youngest son approaches 85, there will be almost 13 million people or five times as many as there are today.

So we have this chart here because it shows us the growing percentage of the overall population represented by these two age groups. Four percent of the country's population was over 65 in 1900, two-tenths of 1 percent over 85; and in 1985 the percentage of those over 85 tripled, and those over 85 today have risen to 1 per-

cent of the Nation's population. By the year 2040 it will be four times.

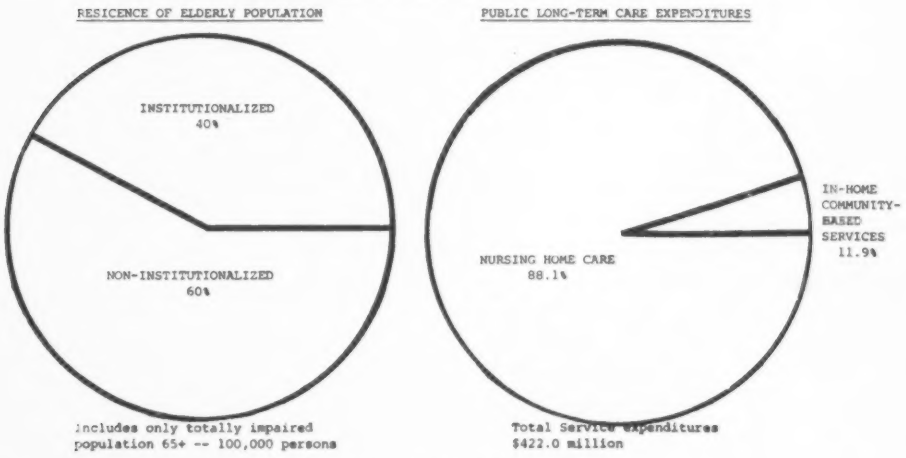
Now, the flip side to that chart is how many people younger than my youngest son are going to be out there working and paying the taxes or making the savings and investments necessary to help my children when they need long-term care; and most of those people are being born now or not being born now, the problem being if things keep up the way they are, there aren't going to be enough of my children's children to provide for my own needs and my children's needs.

So these are the kinds of things that bring us together. I think these are the kinds of things that all of us can agree on.

The third chart shows another very interesting fact that a lot of us don't think about, and that is that even for the 100,000 most severely impaired elderly in Minnesota, most long-term care is provided outside of institutions.

CHART C

LONG-TERM CARE RESIDENCE AND PUBLIC EXPENDITURES IN MINNESOTA IN 1980



SOURCE: "85 and Beyond: The Challenge of Minnesota's Elderly, Hennepin County

Forty percent of the impaired elderly—these are just the severely impaired people over 65—40 percent are in institutions, 60 percent outside of institutions; but when you look on the right in terms of where the dollars are going for the care, only 12 percent of the money is going to 60 percent of the people, and 88 percent of the money is going to provide institutional care.

So again, one of the challenges before all of us is to strike more of a balance, if you will, between the investments that all of us in this society make for the variety of the institutional and noninstitutional care.

So some of the issues that we will be addressing are shown on this frank chart. They include immediate problems like nursing home quality or standards for long-term care insurance or funding eligibility for in-home services designed to help older people stay independent as long as they can.

CHART D

DURENBERGER LONG-TERM CARE INITIATIVE

** Provide tax incentives for long-term care insurance

** Offer tax-deferred long-term care savings accounts

** Maintain high quality standards for nursing homes

** Require tough standards for long-term care insurance

** Expand assistance to families providing long-term care

** Increase support for home health and other support services

** Encourage congregate housing and home sharing options

** Offer home equity conversion financing for long-term care services

Others are longer term issues, how we provide better incentives to finance long-term care in the future, for example, through long-term care insurance or through tax-exempt long-term care savings accounts. Some of the Presidential candidates are now endorsing these kinds of proposals.

Long-term care is an issue which is uniquely intergenerational in its nature. It's an issue which can divide, or it can unite our families. It is an issue as important to my parents as it is to me, as it is to my four sons. It is an issue which is broad and an issue which is complex.

Fortunately, we have some of the best minds available waiting to testify this morning. They have all come in out of the cold to be with us today. We've divided them into four panels, and they will come at these long-term care issues from the perspectives of government, of providers of care, consumers of care, insurers and employers.

Before I introduce the witness, I also want to introduce the timekeeper, Marshall Isabelle. Does everybody here recognize Marshall?

Now, Marshall is going to make sure that all the witnesses stay on time so we can all hear all of the witnesses between now and our lunch break.

I'm going to begin now, and it's certainly a personal pleasure for me to introduce a long-time friend, who naively belongs to another political party, but we've known each other for many, many, many years, and I sure have never thought of him as a politician; and I think now that the community, after he has served his tour in elected office, the community, in a larger sense, has either rewarded him or burdened him with the chairmanship of the Metropolitan Council; and it's my pleasure to introduce Mr. Steve Keefe.

STATEMENT OF STEVE KEEFE, CHAIRMAN, METROPOLITAN COUNCIL

Mr. KEEFE. Thank you very much, Senator Durenberger. I apologize. I have a touch of the weather in my throat, and I can't talk as well as I ordinarily do, which is a bit of a handicap.

I am chairman of the Metropolitan Council, as you said, which is the regional planning agency and the designated area agency on aging. We would like to welcome the Senate Special Committee on Aging to Minnesota and especially to the Twin Cities for this hearing. We're very happy and proud of the programs that we have in the Twin Cities area, and we're delighted that the committee is focusing attention on it.

We recently took an intensive year-long look at the issue of long-term care in the Metropolitan area in 1984. We defined long-term care to include all the services and assistance—and I think it's awfully important to include all the services and assistance—health, social, housing and income programs—needed over an extended period of time by the chronically ill and physically disabled of all ages.

Our findings were virtually the same as in other studies around the country, that the population most likely to need long-term care, the frail elderly, is one of the fastest growing groups in our population. We're seeing increases in the proportions of elderly in the first ring suburbs now; by the year 2000, we expect to see the proportion of the elderly population over 25 percent, which is more than the center cities have ever had.

Frankly, the services aren't out there in the density that they need to be, and that is something that we need to strengthen.

It's apparent to us that the vast majority of long-term care assistance needed is provided by family members, especially women, and that there are some crucial gaps in the community-based system of services that, if we fill them, would help many people who need long-term care to stay in their homes where they prefer to live for as long as possible.

Based on our study of these issues, we have laid out five principles or policies for reshaping long-term care in the Metropolitan area. They are, first, better use of existing resources, including more support of the informal network of family, friends and neighbors; and that's critical, and it's going to be more difficult as more and more people, women, particularly, are working outside the home. The informal care network is more and more difficult to sustain. It also means more efficient use of the housing stock already available, and better coordination among the large number of service providers in the area.

Second, we think it's very important to provide multidimensional/individual need assessment earlier in long-term care, and to develop the service coordination for integrating across housing, medical care, transportation, supportive services and other support needed by disabled people or frail people and their families.

Third, we think it's very important to provide greater flexibility in the use of public funds, to allow for less expensive and more desirable kinds of long-term care services. And we believe there could be wiser use of personal resources, wherever feasible, to pay for long-term care costs.

Fourth, we think we need to have strategies to fill gaps in home-based services needed for long-term care, including specialized housing, personal care and domestic services, transportation, and information to consumers and their families about long-term care services.

And finally, we think it's very important to provide encouragement for joint city, county and neighborhood planning for long-term care.

Since 1985 the Council has been actively working to implement these policies. At the same time, the programs have been implemented by you, the Federal Government, and also at the State and local level to promote similar principles. We would like to mention a few which we think are especially illustrative of the types of efforts going on in our region that we think are reshaping the system in long-term care. Many of these will be discussed in more detail by other panel members, but I would like to try to give you an overview of what we think are the key ones.

First, we believe the single most important change that has occurred in long-term care recently has been the implementation of the Preadmission Screening/Alternative Care Grant program enacted through the Federal Medicaid waiver and State legislation.

This program, together with the State moratorium on new nursing home bed construction, has provided a very powerful incentive to hold down nursing home utilization and, at the same time, to develop the home services needed by the frail elderly with low incomes, who, without this program, would have no choice but nursing home care.

The program is quite specific. It targets those most in need. It encourages flexible use of public funds, it provides a multidimensional assessment of the person's needs, and identifies the most appropriate mix of services for each individual.

Second, we're very interested in the role of local neighborhood and community planning. We think it's very important. We are working right now on a guide for local communities to assist them with that sort of planning, which we expect to be done in April.

It's already clear that the Federal Government needs to allow and even encourage more creative planning and innovation at the local government level, and we think that the most interesting innovations come out of that sort of opportunity for experimentation.

We have a number of interesting demonstrations and trends going on in the housing area. Jim Solem will talk a little bit more about that, but we're particularly proud of the emphasis on thinking of housing not only as shelter, but as an environment that has a very powerful impact on how many services are actually needed; and we see a continued need for Federal involvement in housing, because the people who need housing due to long-term care needs are often the least able to pay.

We have set up a number of local "focal points" for long-term care services. I think, Senator, you're finding with your own parents, that a big part of the concern when people start to near the age where they may need long-term care is getting information. We have a number of consumer guides available, and I'll leave copies of them with you. We find tremendous demand for these, not only from older people, but also from the families of older people who don't know what they can do to help their family members.

And finally, we're looking very hard at long-term care insurance, which we think is an important alternative to protect people. We think it's going to be necessary, ultimately, to have waivers in either State or Federal law or both to make sure that long-term

care insurance works in a complementary way with public programs. We think you might want to consider making long-term care insurance payments tax deductible because of the very powerful impact it would have on reducing medical assistance payments.

We look forward to working with you and your staff. We really appreciate the sort of attention that we've gotten, from you, especially, in Washington and from the committee, in general. We found it a very receptive environment for all our ideas, and we hope to maintain this relationship. Thank you very much for coming.

Senator DURENBERGER. Thank you very much.

Now the Commissioner of the Minnesota Department of Human Services, Sandra Gardebring.

STATEMENT OF SANDRA GARDEBRING, COMMISSIONER, MINNESOTA DEPARTMENT OF HUMAN SERVICES

Ms. GARDEBRING. Thank you, Senator Durenberger. We would join Chairman Keefe in welcoming you to this hearing and back home, and we're glad to have the chance to talk with you today.

My own personal education about the issues of long-term care began when I preceded Steve as chair of the Metropolitan Council and accelerated very rapidly in the last 13 months with my statewide responsibilities in this area. I had not been in this job very long before it became quite clear to me that there was a variety of public policy issues and human needs in the human service area that were going to demand attention, from issues of teenage pregnancy of Medicaid revision to a variety of other programs; but at no time in this 13 months have I been persuaded that there was any issue that was any more important than the issue of long-term care, and we're very happy to be able to talk to you about it today.

As the public official in Minnesota with basic responsibility for implementing public payment for long-term care, I am, of course, quite concerned about the cost of sustaining the current long-term care system, a cost that we know is going to accelerate in the next few years as the country's percentage of elderly people increases; but of course, as I think is apparent to everyone in this room, it is not just a matter of dollar costs that are at issue here because the costs associated with this issue can never be considered solely in economic terms. There are also going to be human costs of the kind that you talked about, Senator Durenberger.

I had a similar conversation with my parents over Christmas, so I'm quite aware of it. There are husbands and wives who worry that their plans for retirement are altered because their spouse is now in a nursing home. There are people of my age and of your age, Senator, who are juggling the demands of caring for their own families and their own children while caring for their parents as well.

There are a group of people that are sometimes left out of the equation, young people who may be injured or crippled or debilitated by some kind of disease, who really are also part of the long-term care system and need to be considered here as well.

It's those human costs and human issues that we need to take into account, along with the economic costs. Because the system of

long-term care services in our country has such a tremendous impact on individuals and their families, we can never forget that the stakes are very high as we begin looking at the transition of this system to a more sensible economic base.

Senator, you asked us on this panel to consider two basic questions, and you've given us 5 minutes to fit them in, and I'm going to try to be brief. First of all, you asked us what we see as the most significant problem in this issue; and second, what can you and others members of the Special Committee and the Congress do to try to address it. So I'm going to focus my remarks on the issue of national concerns.

There are any number of compelling examples as to why stronger national long-term care policies are needed, along with the innovation that Chairman Keefe talked about at the State and local level. One is certainly the disparity in the quality and equality of services among the 50 States and the State resources that are put into long-term care; and the other is just the fact that there are certain kinds of planning that can best be done at the national level in this issue.

I want to talk about what I think may be the best example of this need for national planning and national consideration, and that is the problem of how best to restructure the Medicare and Medicaid system in this country to meet the demands that we know will be placed on it by the aging of the population in the years ahead.

When you think about what the easily articulated term "the aging of the population" really means in terms of its inevitable impact on the long-term care system and particularly on public budgets, it's clear both that a national debate about possible financial solutions is needed and that congressional action, I think, will finally be required to put those mechanisms in place.

Simply put, we know very well that the present Medicare and Medicaid system currently structured is not going to be adequate to handle the demands placed on it in the future. Already in Minnesota long-term care accounts for 70 percent of the $1 billion-a-year Medicaid budget on an annual basis, and there are projected increases in the number of Americans over 65 and, of course, particularly in the number of Americans over 85; and we know that that's going to increase, not only the absolute dollars, but, we believe, the percentage share of the Medicaid budget.

As you know, the spectre of the long-term care future beyond our individual and our national financial needs has become a topic of conversation for some time now, and you have certainly been a leader in forcing that issue to the public agenda. One result of these concerns has been the recent growth in the development of long-term care insurance, which I think in Minnesota we're doing very well on; and in addition, there are a number of innovative proposals, in particular, one growing out of the Villers Foundation, the American Association of Retired Persons, and the Older Women's League.

Dr. Kane, one of today's panelists, is a particularly well-known expert on that issue, and I hope he'll talk to you about it; but I would urge you and other members of your panel to give close consideration to what's commonly called "Medicare Part C" because

we think that's an important piece in trying to put this puzzle in place.

Finally, I would only reiterate something that Chairman Keefe has said and that you began with in your earlier remarks, and that is that this is a very critical intergenerational issue. As we try to come to terms with it, I think we need to understand that its impact really projects very far out in the future. New financing mechanisms are certainly needed, but they need to take into account, as well, the concern for your children and all of our children and their economic well-being.

We thank you for the chance to testify today.

Senator DURENBERGER. Thank you very much.

Next is Jim Solem, who is the Executive Director of the Minnesota State Housing Finance Agency.

STATEMENT OF JIM SOLEM, EXECUTIVE DIRECTOR, MINNESOTA STATE HOUSING FINANCE AGENCY

Mr. SOLEM. Thank you, Senator, and good morning.

The Housing Finance Agency has been in the long-term care business in a variety of different ways really since it began in 1971. We have financed 7,900 units of elderly housing in 121 different developments in all parts of Minnesota from Blackduck to Minneapolis; and in fact, the building where we're meeting today has a mortgage from the Minnesota Housing Finance Agency. I doubt that you'll find a better facility of any kind, any place in the country than the work that they do here in this particular building and this particular development.

In addition, we've done literally tens of thousands of loans to elderly, as well as nonelderly, for home repair, energy conservation, accessibility modification; virtually anything you can do to a house to make it last longer and be better. We've tried to figure out how to finance and make work almost any kind of form you can think of. I think we've learned a lot about the way in which housing can be and ought to be a resource in long-term care, and I'll try to get right to some specific recommendations that we have about that.

First of all, in terms of dealing with facilities like this or the others that we have around the State, most of the ones that we financed have lower income individuals in them, and use Section 8 subsidies from the Department of Housing and Urban Development.

We've done a fairly significant study about the service needs of the residents of these buildings. One of the things that we've learned is, first of all, perhaps not in a facility like this where they do have full-time staff that are specialists, but when you get into the smaller rural communities, the folks who manage the buildings are concerned about the building custodial services and financial management. They aren't specialists in coordinating services and all of the resources that you can bring to that building.

And we think it's important that Congress and the Department of Housing and Urban Development think seriously about the long-term management of that service package to those folks in that building and that HUD consider the possibility of some additional help in terms of adjustments in the management fees that go to

people who run these buildings, who take responsibility for the day-to-day management of the building, of $2 or $3 per month per unit, which would build some capacity for social service coordination and for crisis management.

One of the things that we have learned and the folks who manage the buildings that we have financed have learned is that as the population grows older, the problems of crisis management, taking care of very serious and special problems that come along, become greater every day, and there are additional management capacities and resources that are needed to do that. So that would be our first recommendation, that we think seriously and that Congress and HUD think seriously about the long-term capacity in terms of managing the services for those buildings.

Home equity conversion has been talked about. I think it's on your list. We just completed a major study that the legislature asked us to do on the possibility of home equity conversion in Minnesota, and the possibilities are substantial. In the Metropolitan area, for example, the data indicates that home owners over age 75, over half of them could get at least $200 a month from income in the equity in their home. In the rural areas, the numbers are a little bit less than that, but they are larger than we thought they would be when we started.

Now, you just passed a housing bill in Congress that has a home equity demonstration provision in it. You need to hold HUD's feet to the fire on that, and first of all, make sure that they actually do it; and second, when they do it, that they allow a mix of both public and private lenders to participate in that program because I don't think you're going to find very many private lenders that are going to be willing to make home equity loans in Fulda, MN.

So we need to put together a loan program that combines the best of what public and private agencies can do in terms of working on a demonstration of how this will work in all parts of Minnesota.

And finally, we need to think much more creatively than we have been doing about the use of the existing stock of housing. We aren't going to build many more developments like this one. The resources simply aren't there to do it.

Senator DURENBERGER. You're talking about financial resources?

Mr. SOLEM. Some financial, subsidy resources, the capital to do it; and it can't be done at affordable rents without a lot more help than we're presently getting from both Federal and State governments. The rent on a building like this, if you tried to do it today, would be $575, $625 a month without the subsidy and without the assistance. In rural Minnesota there is just simply no potential to do that.

What we're trying to do is look at shared housing, home sharing, accessibility modifications of the existing homes so that folks can stay in their homes for a longer period of time; but as Steve pointed out, we have to do a much better job. We need some demonstration efforts to link up social services with that use of the existing home so that we build a management capacity to make certain that folks who get the assistance to modify the home are then also plugged into the social services and into the social service network

so that the care system functions in a way in which they need and the home can, in fact, be used as a real resource in long-term care.

Senator DURENBERGER. Thank you very much, Jim.

Our next panelist is the Dean of the University of Minnesota School of Public Health, Dr. Robert Kane; and Bob has been referred to earlier. He, like the other witnesses, has been a fast witness at our health related hearings, and Bob Kane, we welcome you here today.

STATEMENT OF DR. ROBERT KANE, DEAN, UNIVERSITY OF MINNESOTA SCHOOL OF PUBLIC HEALTH

Dr. KANE. Thank you, Senator. Today I would like to talk about the repricritization of the same three topics that keep coming up in all of our discussions about health and social services, namely, access, quality, and cost. Today, however, we're changing the order of those priorities, looking at cost as our primary concern.

One of the most important lessons that we need to take away from these hearings is the need to redirect our concern from whether we're spending too much to whether we're buying enough with the dollars that we're spending. We want to look here at some of the things that might be proposed to help distribute the cost of care more equitably and also to increase our purchasing power.

One of the lessons from the number of studies that my wife and I and other people have done looking at and how other countries have organized their long-term care is the tremendous importance of centralizing payments.

In that context, we need to be very careful to recognize that the bottom-line issue with regard to long-term care is overall expenditures and that much of the discussions about the shifting of money from public to private and the enthusiasm for long-term care insurance may be more a bookkeeping tactic than a real issue. The real issue is how much money we spend as a country on long-term care and what we buy for that money.

The other important part of cost control is avoiding creating inappropriate incentives; and, as already been mentioned, one of the very important areas where our system creates inappropriate incentives is the way it treats families. We have failed to support families as they struggle to care for their dependent relatives; in the worst cases, we penalize them for providing needed support. We deny needed support to spouses, spend unproductive efforts trying to pressure unwilling or unable relatives to offer support that they can't provide.

We need a policy that recognizes the central role of families and supports them in their efforts to give care. That may also involve giving care to families in order to allow them to support the people that they are caring for.

With regard to access, we have already talked about the importance of some form of universal coverage. Universal coverage is not going to necessarily mean spending more money than private coverage, as long as we compare programs that cover all the people. If we try to save money by not covering a proportion of the population, then obviously, a private policy can do that more effectively. But we want a universal program that provides at least a mini-

mum level of care for all citizens and then allows those people with more means to supplement that with different kinds of care.

We also want a system of access that will allow us to create sharper incentives to deliver better forms of long-term care. Our current system is designed in a way that would be totally unimaginable to somebody coming down from Mars. If we look at how we organize our system, we observe that we define it by payment mechanisms, rather than by services.

What we want to create is a long-term care system that allows us to provide more individualized forms of care that would allow us particularly with the breakthroughs in new kinds of information technology, to deliver tailored packages to individuals.

A well-known gerontologist, Elaine Brody, once referred to the nursing home as a Procrustean bed in which the patient was adjusted to fit the shape of the bed rather than adjusting the bed to fit the shape of the patient. That's an important distinction. We're fortunate here in Minnesota to have some examples of very creative mixtures of community care, housing and service packages that point the way to the potential for really effective and affordable innovations.

In the area of quality we need to be very careful that we insist on full accountability. Paying more should not be confused with necessarily getting more. Indeed, you can find tremendous variations in quality among nursing homes being paid at the same rates.

Simply equating money with quality is a mistake, especially in an area that is so heavily dominated by proprietary interests. It's very important that we send out to the providers of care clear market signals about what it is that we want to buy. It is possible to develop a win/win situation in which we can get better care, affordable care, and get it in a system that is privately operated.

The way to do that is to rely more on outcome, to insist on accountability based on outcomes where those outcomes are expressed in terms of the proportion of reasonable expectations that are actually met. We have the ability today to implement that kind of a program.

It is important to send a message to the long-term care providers that we really expect long-term care to make a difference. We have fallen into an unfortunate self-perpetuating trap of viewing long-term care as a burden, as a negative experience, which then tends to attract less than the best people into that area, then instead of getting better, it tends to get worse.

There is no better place, no more appropriate place in the country to really make a beginning to change the whole nature—the conception of long-term care than here in Minnesota. We have a proud tradition in that area. We have a great deal to build on. We could be setting the example in the rest of the country.

Senator DURENBERGER. I think we may get a response to that challenge from our provider panel. It's a very appropriate crowd for it. Thank you.

The fifth of our outstanding witnesses on this panel is Cynthia Polich, who is the President of InterStudy, which is a health economic research group located in Excelsior. They have created lots

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of turmoil in the acute care field with competition, and now they are headed into long-term care, and we welcome you Cynthia.

STATEMENT OF CYNTHIA POLICH, PRESIDENT, INTERSTUDY

Ms. POLICH. Thank you. The bad thing about coming at the end of all the panelists is that there are so many things that have already been said that I agree with wholeheartedly. I will try to keep my remarks brief and move directly to my key concerns regarding long-term care.

My biggest concern is that what we refer to as a long-term care system in the United States is not really a system at all. It's a conglomeration of many services and funding sources. It's short-term rehabilitative care after hospitalization. It's long-term custodial care in an institution. It's home care. It's social services. It's care provided by family and friends.

It's funded by Medicaid, Medicare, the Older Americans Act, Social Services Block Grants, State programs, private out-of-pocket payments, and private insurance. The large array of services and funding sources, however, masks the fact that long-term care is primarily funded by Medicaid and out-of-pocket payments. In addition, those funding sources primarily pay for nursing home care, as many have already mentioned earlier in this hearing.

This method of funding has created our problems—problems with a system that is fragmented, excessively costly, biased toward acute care and biased toward institutional care. It requires frail elderly to impoverish themselves before being eligible for assistance. It creates incentives for nursing home placement because there is inadequate funding for home health care and social support.

It's also extremely confusing to the elderly, many of whom believe that Medicare will cover their costs, and it's not until they get to the point of entering a nursing home that they realize they have no coverage.

Also, the system works as well as it does only because of the extreme dedication and sacrifices of the families of the frail elderly. Without this, our system would not be merely inadequate. It would be disastrous. That fact must be acknowledged.

But I'm not telling any of you things that you don't already know. The point is that the system needs significant reform, and it needs it now. I would like to focus on what needs to be done at the Federal level.

First of all, we need to set goals for what our long-term care system should do. I have a set of nine that I would like to submit to you.

First, we need a system that provides services along the full continuum of care, and is not biased toward or away from any one setting; second, that has incentives to contain both public and private costs; third, that controls utilization and encourages appropriate placement; fourth, that does not promote cost shifting from one client to another or from one funding source to another; fifth, that integrates acute and long-term care services; sixth, that promotes quality services; seventh, that encourages and rewards family support; eighth, that targets services to those in greatest need; and

ninth, that targets public funding to those without the financial means to provide it for themselves.

A tall order? Yes. Impossible? I don't think so.

In order to accomplish this kind of reform, though, we need to concentrate on reforming the financing system. I think all of us who have worked in human services realize that services and programs follow the financing system——

Senator DURENBERGER. This is the business about the patient being shaped to the bed instead of the other way around.

Ms. POLICH. Exactly. There have been several proposals over the years to try to do this. They have included block grants to the state, increasing the private financing of long-term care and making major changes to Medicare and Medicaid.

I would urge you first not to seriously consider long-term care block grants to the State. I think it's unfair to burden the States with the long-term care dilemma. I don't say this because I think that all States are incapable of dealing with the issue. In Minnesota, the State has been very innovative in spite of Federal constraints. I say this because not every State is Minnesota or Wisconsin or Massachusets. The tremendous disparity between States in the scope of, access to, and quality of long-term care services is appalling.

The only way that we can guarantee adequate access to long-term care for the elderly is through Federal programing.

Second, I would urge you not to be seduced into the belief that private financing of long-term care will reduce the need for public financing. I don't believe that can happen. Private financing, long-term care insurance, long-term care IRA's, home equity conversions, life care communities can serve a portion of our population and can serve them very well.

Unfortunately, this group will also be those who are least likely to spend down to become eligible for Medicaid. Those that will be eligible for Medicaid will be least likely to afford the high long-term care insurance premiums. Thus, we'll still need public financing.

What long-term care insurance will probably do—and it will be a very positive outcome—is to spread the risk of out-of-pocket payments for long-term care. Thus, what we should be aiming for is a system that encourages private financing for those who can afford it, but does not depend upon it for those who cannot. At a minimum, we should be looking at a system that maintains our current level of private financing, but in a more equitable way.

Finally, my recommendation—I strongly believe that Medicare and Medicaid must be restructured; that long-term care must be removed from Medicaid. Currently, Medicaid is a schizophrenic program. It should be returned to its original intent, to provide health care to poor families and children; and long-term care should be integrated with the acute care of Medicare and make that a program for all elderly. Thank you.

Senator DURENBERGER. Thank you very much. I want to thank all of the panelists, and let me say to those of you who are wondering if this is all we're getting from these people, the answer is no. I just—this is just a sample of all of the testimony that is being presented, and what we heard here this morning and will hear this

morning is merely this 5-minute highlighting or summary of what each of these witnesses, to the degree that they represent institutions, have provided as their contribution to our understanding of the public policy future of our long-term care.

So on behalf of the members of the committee and its chairman, John Melcher from Montana, I want to express my appreciation not only for being here today, but for the contributions that, through you, Minnesota is making to shaping the long-term care policies in this country. Thank you very much.

Our next panel will be consumer participants of long-term care, Etta Furlow, Gladys Murray, Iris Freeman, and Iris is here representing the Minnesota Alliance for Health Care Consumers, Harold is the chair for the Long-Term Care Committee, Metropolitan Senior Federation.

These four people are not necessarily the best witnesses that we could find because there are so many good witnesses, so many good people, who are working as consumers and on behalf of consumers. These just happen to be four of the people that have been the most active in our community on behalf of people in need of long-term care, the elderly, those who are seriously disabled; and for one reason or another, despite the fact that we had a lot of people to choose from, these four people have, by their own experience and expertise and other contributions, come to the attention of the Committee. Our first witness in this panel is Etta Furlow. Etta?

STATEMENT OF ETTA FURLOW, CITIZEN, LONG-TERM CARE CONSUMER

Ms. FURLOW. OK. You just said my name, Etta Furlow. I'm out of hibernation today. I usually go in after Christmas and stay in until Ground Hog Day, but this is one of my causes, so they had to get me out today.

I was a nurse for over 50 years, and I've seen all phases of nursing and giving care. I worked hard in the humanities. I feel that I have. We worked 12-hour days and got $50 a month; so when you had a cause, you had to love something, be dedicated to something; and I was there doing those things, and I've worked.

Now I'm receiving those things back, and I think I've been very blessed with the laws that have been passed. I worked hard to get an 8-hour-a-day law for nurses. I worked hard to get a wage-an-hour law. So I've been working a long time on the road to get where we are today, where the money is concerned. It was a matter of food, shelter, and those things, the necessities of life to survive to get us to where you all are talking money today.

So I, with emphysema, I know there is no cure, and it's something I've come to, you know, the crossroads with all I've got to live. I'm not looking for a magic cure; and it can happen to anybody, although some things don't catch up with you until late in life.

So the laws and things that they are making today, I want to see them in Washington make laws for the young and the old because they are born with bad hearts and lungs, and we might not get one until we get old. They get broken legs. They get diphtheria. They get appendicitis, those things. They don't have no ages on them,

nor no time or when or who. It happens to everybody, and that's what we got to look at. I don't think that they are going to clear these things up.

And the insurance companies, they've got fine writing down there with existance circumstances, 6 months that they don't pay—you know, preexisting circumstances. Well, sometimes they haven't preexisted. Maybe they have been there a long time, but you were working until you retired so they could take over because you're looking forward to that day.

Then the act of God and an act of war, they don't pay. We're all God's children here on Earth, and I think, with our Government, we have worked, sacrificed, and gave. You young people today, you all are my yesterday, and I am your tomorrow. So you're making it, and if you don't, what you see—you never know what.

I want good laws passed. I want our Government to be in charge. I agree with everything that's been said here, the people that were on the other panel, but I want them to see that there are laws to see that these people that are doing these things are accountable; and I hope people are choosing jobs, whatever they are, jobs that they love and work that they love to do and not for the money because we all got mothers, fathers, and things.

Sometimes I say I'm glad my mother's dead because some of the things that I see that happen to older people, I think I might be in danger of killing somebody because I wouldn't want it to happen to my mother. I know she would give her life for me if somebody ever abused me, and I don't want that.

I want to stay in my house. I want to stay there. I've got some pets. I've got three dogs and three cats, and they live there with me. The people come and go, "hi," "bye," "see you tomorrow," "get to you later," "call me if you need me;" and I want a loaf of bread, and they are living in Minneapolis and I'm in St. Paul. You know I'm not going to call them to bring me a loaf of bread.

I have neighbors living next door, and they have been very nice to me. The people that I planned on and thought that I was going to be with in these years, they are dead or moved away or possibly in a worse condition than I am. The people that are taking care—looking after me now are the young people. Some of them I haven't known, not even the ones that I worked with. They are different ones. They come to see how I am. The children, they come by, and I think all the freakets come to my house.

I just want good laws passed, and I want these people licensed and accountable. They got them there. The people that are working and carrying out these things, they are good. I just want strength in them because we are all on that road. That's all. I know my 5 minutes are up.

Senator DURENBERGER. You hit it right on the head. Thank you very much, Etta.

Our next witness is Gladys Murray. Gladys, welcome, and thank you very much for taking your time to be here this morning also.

STATEMENT OF GLADYS MURRAY, CITIZEN, LONG-TERM CARE CONSUMER

Ms. MURRAY. Thank you very much, Senator Durenberger. You write letters to me every month, sometimes twice a month, and sometimes I write back to you, so it's a pleasure to be here and doing what I can to promote the attention to the issue of long-term care.

I have about three components that I would like to emphasize of what can be done at the Federal level for long-term care. The first thing I would like to mention—well, I'll start with what I've written because 5 minutes will go pretty fast; but in summary, before I start that, it's important that we plan this planning for long-term care just as carefully as we do our health insurance.

When you take employment, you investigate what are the fringe benefits that go with your position. You always investigate the health insurance. Why can't you investigate health insurance along with long-term care insurance in the same breath? When you're buying it when you're 21 and you're paying for it until you're 65—you don't intend to use health insurance every year. When you buy car insurance, you don't intend to have need for it. When you buy house insurance, you don't want to ever have to use it. Why can't we start paying for our health insurance—long-term care insurance when we start our career of employment?

I represent the middle income population, so I would say I'm in the +1 standard deviation to the −1 standard deviation. Two-thirds of the population of this Nation are employed working their butts off to make a living, and why do we fail to purchase long-term care insurance since it protects our assets? When I buy a new car, I never take it out of the showroom until I make sure I have adequate coverage on it to protect my assets. Same with my housing.

I'm sitting up here today not because I was personally in a long-term care facility, but my husband and I were on our way to visit a friend who was dying in Sioux Falls in a hospital. In the blinking of an eyelash at 20 after 8 on October 31 in 1985, Dr. Murray, my husband, who had worked his butt off, had a very successful practice, been past chairperson of the Chamber of Commerce, never missed Rotary on Thursdays, very prominent in the church, a really go-get'em kind of fellow, 210 pounds, 6'7" in height. He felt that he was shaping the world. He was.

In the blinking of an eyelash, he became a vegetable. That's why I'm sitting here today. I had worked for 31 years in the school system. Many, many of those years I was Director of Special Education and Vocational Education. We thought we had our retirement planned. He was never going to totally retire. When the weather turned cold in the fall we planned to go South. He was going to come back at the end of the month, see that the people were running everything right and then back to the golf course. We had bought a retirement home on the second tee in Green Valley, AZ.

We had thought we had our act together, but believe me friends, in the blinking of an eyelash on the way home today, you don't know what's going to happen to you. We didn't know that day either. I started off, oh, God, don't let him die, don't let him die,

don't let him die. There will be a miracle, there will be a cure. He will come out of a coma. Eventually, it came to "thy will be done".

I took early retirement because I wanted to get on the Met Council Health Planning Board to help other families. The three things that I want to see happen as a result of you're working with Senator Durenberger here today is that there become some kind of long-term care insurance purchased, not only by the aged population, but by anybody who is working. People of any age can blink their eyelash and become a vegetable that fast too. It isn't just the frail seniors. We all become frail. We all become dependent when your brainstem is damaged very seriously.

I used to be a vocational director at school, and the vocational construction trades class built a house every year. I'm just appalled as I think back to all those steps, all of that glitter that we put into those houses and not very much attention to a barrier-free design. Oh, there was a heavy emphasis on energy efficiency. Why can't we get some assistance in putting that same emphasis on multigenerational living when you reach that stage in life? Why aren't houses built so it would be so easy to accommodate someone who was a victim of an accident and became forever more in the category of long-term care?

I recently built a house. Believe me, there isn't a door that isn't a yard wide.

We thought we had every insurance that you could ever need. My husband's father was an insurance broker or salesman or whatever you want to call it, but he thought insurance. Nobody tried to peddle him insurance for long-term care, and he was an easy sell.

That's what we need. We need to purchase health insurance coverage to protect our assets in that domain. We need to purchase long-term care insurance to protect our assets in that domain, just the same as you have it on your car, just the same as you have it on your house and car, just the same as you're carrying liability insurance.

We want to have some model housing that puts the same emphasis on long-term care provisions in a house as we now have on energy efficiency. You wouldn't begin to buy a house unless you asked the R factor of that wall, those windows, that roof. Why can't we ask can a wheelchair make it around this corner? Can a frail hand manage that tap? There just needs to be creativity in providing leadership to builders and owners.

How long would we have lasted had situations been changed? My husband was 6'7", and we were talking about the people fitting the bed and making the bed fit the people. If you don't fit the bed, you, as the one that pays the bill, buy the bed that fits the patient because there is a standard sized bed in that facility.

My time is up. I've emphasized three things. I hope that something will come of it. Thank you.

Senator DURENBERGER. Thank you very much. The third witness is Iris Freeman, and I mentioned earlier that Iris was on this study, but I didn't identify the study. The National Institute of Medicine undertook a study of nursing home care, and they had 20 experts from around the country. It just happened that two out of the 20 were from Minnesota. One has already been referred to. Dr. Kane referred to his collaborative work with his wife, Rosalie Ann

Kane, and she was on, and so was Iris Freeman, who I have already introduced as sort of the core, I guess, of the Health Care Alliance here in this community. We welcome you today.

STATEMENT OF IRIS FREEMAN, MINNESOTA ALLIANCE FOR HEALTH CARE CONSUMERS

Ms. FREEMAN. Thank you, Senator. It's also an honor to be sitting among the people who galvanize my day. The Alliance is a membership organization of nursing home residents and their families. Its professional staff provide educational programs throughout the State of Minnesota and nursing home ombudsman services under the Older Americans Act within the seven-county Metropolitan area.

Our organization has three principal goals. One is that nursing home residents receive good care in a safe environment. Second is that they have adequate financial resources for the cost of their care and for personal use. Third is that they participate effectively, to the degree possible, in decisions that affect their lives. Let me touch on issues in each of these three areas in what will be a "Reader's Digest" version of my written testimony.

In the quality area, the Nursing Home Reform Amendments to the Social Security Act, passed in the reconciliation package last month establish a sound legal basis for the markers of quality indicated in the Institute of Medicine report, but we still need resources for our State health departments, so that health department surveyors can be well trained and effective and fair.

The legislation is gratifying, but what is still left to do is a tall order. Ongoing congressional interest will maintain a sense of urgency in the Health Care Financing Administration.

Quality for nursing home residents can sometimes also mean social service agency intervention in what can best be described as "old family wars." They can occur around an instance of admission; they can occur around treatment decisions, they can occur with issues of money. On such occasions, county adult protection and county attorneys are sometimes a little reluctant to butt in because it's family, but still, the nursing home resident, in terms of quality, is caught in the middle. It's not necessarily an area for sweeping federal reforms, but it's certainly one that deserves our attention when we talk about the comfort and safety of the resident.

On to money. Even with Minnesota's leadership in State laws that diminish spousal impoverishment, particularly in the area of assets and in the homestead, the spouse at home with low income still suffers. Our client case records express the tragedy in a better way than I can describe it. We commend your personal work and your leadership toward the solution of this problem.

Second in the area of money is the personal needs allowance, which is all a recipient in a nursing home has left after the spend-down establishes her or his eligibility. At $40 a month, Minnesota exceeds the Federal floor, but nobody I know can afford clothing, toiletries, haircuts and recreation on $40 a month.

It's fair to say that even the best facility in America can feel like an abusive environment when someone has no opportunity at all

for self-expression. We need an increase in the Federal floor. We need an increase in the State level.

Two items of nonregulatory quality assurance: On the day that regulation is perfect—and I suspect that that's going to be a cold day too—we're still going to need a less formal means for helping nursing home residents. Many problems aren't direct hits on laws or regulations. They are human events that require mediation, and this is the role of the nursing home ombudsman.

The four ombudsman caseworkers in our office did over 1,500 cases and roughly 2,000 brief contacts last year. We send client satisfaction surveys after cases are closed to see what people thought of the service, and to a great extent, they are satisfied with the result. Even more indicative and pleasing for us is that people are pleased with the attributes of the caseworker. "She listened; she took me seriously." That's a service in itself.

By contrast, my ombudsman colleagues often feel that nobody is listening. We're eternally in that bind of sending out for reinforcements, and all anybody sends is new quarterly report forms.

The 1987 reauthorization of the Older Americans Act helped us to clarify the issue of our mandate, but it didn't really help our budget a whole lot. The State and substate ombudsman offices need, at this point, a budget that is more clearly tied to the number of nursing home residents in our jurisdictions and the number of elderly people in our jurisdictions.

Finally, since our organization began with resident councils, self-help groups in nursing homes, I should express that the people who are informed, people who are involved in the decision making of a home, are people who can solve problems and disputes at the source.

Minnesota here, too, has led the way in council development, both in resident and family council development, and we know that councils don't spring forth from the Earth. They are the product of hard work by consumers and nursing home staff.

We took an unprecedented step in Minnesota in 1985 by establishing a small surcharge on the nursing home licensing fee to create a fund for strong resident and family councils. We would recommend that the products be studied as a potential piece, a small piece of the Durenberger national long-term care initiative.

Thank you very much.

Senator DURENBERGER. Thank you very much. I appreciate that. You mentioned a couple of the things that happened in the continuing resolution and reconciliation in the area of nursing home quality. Obviously, it was very important, sometimes contentious, but I think it was one of those areas in which, because Minnesota had done a lot of those things already here in the State of Minnesota, we were able to shape the Federal legislation, and I appreciate your mentioning that.

Now, our final witness on this, the consumer panel, who has a very broad constituency, is Harold Berntsen, and Harold, as I said earlier, is the Chairman of the Long-Term Care Committee of the Metropolitan Senior Federation. Harold, we welcome you.

STATEMENT OF HAROLD BERNTSEN, CHAIRMAN, LONG-TERM CARE COMMITTEE, METROPOLITAN SENIOR FEDERATION

Mr. BERNTSEN. I want to thank you for being so interested in this area of long-term care. I am very pleased that I was asked to serve as one of the members of the consumer panel. Because of time limitations, I will attempt to be brief. I am aware that the timekeeper is on the job. In my written testimony previously submitted, I called attention to several real life cases, which pointed out the tragic things that happen to some people when they face long-term care needs and old age. I also have some perceptions of attitudes which I have observed during the last several years. They might not be news to many, but I feel they accurately illustrate the feelings of the elderly in the area of long-term care:

A, the general fear that catastrophic illness or injury will cause impoverishment is widespread. B, many of the elderly fear that they will have to move from home or apartment if struck by chronic illness or injury because of increased cost. C, many of the elderly feel it would be demeaning to be forced to accept welfare type programs. They believe that, after living productive lives, they should be entitled to continued independence. D, a large number of older persons prefer the idea of living at home, using home care services, instead of moving to a nursing home. And E, a widespread feeling exists that our Government, including the legislative branch, has failed to cope with long-term care coverage and other medical problems of seniors.

Please understand, I'm speaking as a consumer. One thing I want to make clear from the outset is that what the Minnesota Senior Federation feels is most urgent on the Federal level is the enactment of a national health care plan for all Americans which will eliminate the cracks people might fall between. It must be a plan which offers continuity and completeness of service and one which addresses frankly the problem of quality care. This plan should be available to all without a means test. A national health care plan is one of our highest priorities.

Further, because we realize that such a plan may take years to accomplish and knowing that our senior population cannot wait, we must take immediate steps to patch up our present Medicare Program in an effort to eliminate the big gaps that exist in long-term care.

In pursuing this, the Minnesota Senior Federation supported H.R. 2470 in the House and S. 1127 in the Senate because these bills do advance present long-term care coverage, and they have both passed their Houses; I will note here that Senator Durenberger is on the conference committee which will try to bring these bills together, and we are very pleased about this because we know he is sincerely interested.

The Senate bill and the House bill do advance present long-term care coverage, but we feel that they fall short in preventing impoverishment of the elderly who suffer from chronic illness or injury.

S. 1127, the Senate bill, which gives 150 days for skilled nursing care in a nursing home and the home care part of it, which, if extended, can go to 45 days, are limits which we feel are inadequate. To the person who is elderly who has two or three chronic condi-

tions, not too uncommon nowadays, and the person who is going to live several years with chronic conditions that will continue over the period of those years, possibly until death, the 150 days, is very short, as is the 45 days for the home care. Such persons will face financial ruin paying for long-term care.

Likewise, we feel that for outpatient drugs, the deductible is too high. The spousal impoverishment protection is too near the poverty line, and there is no respite care provided in the Senate bill. It is plain that this bill does improve things, but does not go as far as it should. Coverage must be increased in order to prevent financial disaster.

The Minnesota Senior Federation supported a bill introduced by Representative Pepper, H.R. 65, many months ago. The Federation endorsed this bill because its coverages in all areas of long-term care were more complete than in any other bill we had seen. Our National Issues Committee felt that both coverage and financing seemed to be very well addressed, and we continue to support the principles of the bill even though Representative Pepper withdrew it some months ago.

Senator Pepper has recently introduced his home care bill, H.R. 3436, which presents a very sensible approach in providing for long-term home care assistance for the chronically ill elderly, disabled, and children. This bill covers all the areas of need for home care. Quality assurance is addressed. Cost control is provided. Financing is progressive, and it will more than pay for itself we are told by the Congressional Budget Office. We feel this bill does a better job of addressing these long-term home care needs than any other bill and, therefore, should be passed.

One basic thing, we feel seniors really want is to live their older years in dignity without the fear of impoverishment because of catastrophic illness or accident. Most seniors want to remain in their homes as long as possible.

It is a proven fact that keeping senior citizens in their homes is by far the least costly alternative to sending them to nursing homes. Studies by the Minnesota Human Services Department, by New York State, and by Aetna Insurance Company offer substantial proof that millions of dollars are saved by allowing people to remain at home as long as possible and not placing them in nursing homes. If home care programs can save so much, then why can we not expand them further to accomplish this saving?

Someone mentioned that private insurance plans and programs are available. What we understand in the Senior Federation is that a large portion of the public cannot afford to avail themselves of these plans. Only strong action by the Government can stem the tide of impoverishment and bankruptcy for a large proportion of the elderly because of catastrophic illness or accident.

The Government must accept its responsibility for establishing minimum standards, quality control, and availability of coverage for all, regardless of income or health conditions.

Senator DURENBERGER. Very well done. I thank all of you on this panel very much, ladies and gentleman, for being here, and your statements will be made part of the record.

Now, our third panel, the providers perspective on long-term care, will come from Dale Thompson, who is the Chief Executive

Officer of the Cambridge Nursing Home; Gayle Kenvold, who is the Executive Vice-President for the Minnesota Association of Homes for the Aging; Pat Adams, the Director of the Dakota County Public Nursing Service; Adele Mehta, Case Manager, Senior Community Services; and Sally Knutson, Medical Personnel Pool.

I might mention for those of you who like to read material on this subject in your spare time, the Commissioner—excuse me, the Secretary of HHS, Dr. Otis Bowen, had a committee on long-term care health policies which he put together, and the person that he chose from Minnesota to represent all of us, from a provider perspective, looking at this, was Mr. Dale Thompson, and this is their report (indicating). You can see what it looks like, a report to the Congress from the secretary of the advisory committee of which Mr. Thompson was a member.

Dale?

STATEMENT OF DALE THOMPSON, CEO, CAMBRIDGE NURSING HOME

Mr. THOMPSON. Senator, thank you. Am I speaking into the right microphone? Can you hear from the back? We do have a very determined timekeeper here, don't we? It is indeed a pleasure to be able to testify here this morning; and Senator, on a personal note, your special understanding and interest, from a provider standpoint, on health care issues really is a unique and important aspect in Minnesota, and we do appreciate the work you have done in health care.

I speak as a provider not only in nursing home care, but also as a home care provider; and we have a number of senior apartments, where we provide services much as the facility you're in today.

I think that all of our comments as providers and the comments of others really can't mean a lot to Members of Congress or to the rest of us unless we really take note of the testimony of Etta and Gladys. Those of you who work in long-term care and were ready to stand up and cheer when they made their comments, I think, really understand their issues.

Louis Armstrong was once asked to explain jazz, and he said, "Brother, if you can't feel it, I can't hardly explain it to you." And you really do need to have some personal relationship or some personal experience with long-term care to understand the magnitude of the problem and the importance of the problem today in the short run and going forward, and I urge you to really consider and take to heart some of the comments they made.

My comments will be from somewhat of a national perspective representing the American Health Care Association and Care Providers of Minnesota, its State affiliate. Gayle is going to make, I noticed in her comments, some specific comments on Minnesota, and I'll try to draw some national focus on concerns of providers.

First of all, I would echo an earlier comment that we do need a national policy on long-term care. A very difficult task, but we need to take a very fragmented delivery system and put it together some way. We need to define long-term care as continuing care ranging all the way from a little help to keep people in their own

homes to the need for skilled nursing care, 24-hour skilled care in a skilled nursing facility.

If we're able to do that and do that in a very constructive way, it will help consumers know what's available, what has to be covered privately, what can be covered under various government programs. It will let providers move forward in a very creative and innovative fashion to design the programs to meet needs; and it will, indeed, help the private sector, who you are going to hear from next, who are trying to develop long-term care insurance products, to know exactly what they are insuring, what benefits they need to provide.

It's not an easy task, but I know that providers, consumers, regulators, and legislators alike recognize the need for a national policy on long-term care, and we do need to move forward with that item on our national agenda.

A second concern of providers is that of moving forward and continued working on higher standards of quality. The recent quality legislation passed by Congress is progressive, and we, indeed, support it. Many of the things that were passed by Congress have already been implemented in Minnesota, but that's not to say that we can't work harder and try to meet and exceed some of the new standards that are coming on the scene.

As we implement new and higher standards of quality, we really have to recognize the limits that do exist in terms of the reimbursement and dollars provided to meet those limits. The average cost of a nursing home stay in Minnesota, for example, is somewhere between $50 and $60 on average.

I know there are many people in this room that stayed at a hotel last night for $75 to $100 a day, and when one considers the fact that the $50 or $60 a day in a nursing home includes 24-hour nursing home care, nursing care, complete meal service, transportation, social service, recreation, personal care items, personal laundry services and the like, long-term care in that perspective in a nursing home stay becomes a pretty good bargain; and there are limits to what we can provide. We do need recognition that when higher standards are set, we need the financial resources to find the payment.

A third concern that we have as providers in the short run and, certainly, into the foreseeable future has to do with staffing, nurse staffing in our facilities, RN's, LPN's, in particular. There is a severe shortage in various parts of the country, beginning to show up in Minnesota also, in the shortage of RN's and LPN's. We need to do new and creative things to attract top-notch people to the nursing profession. We have to get them excited about working in long-term care. We have to explain to them what the opportunities and rewards are in being involved in long-term care.

Some recent legislation introduced in the Senate we are in full support of as a professional provider association. It goes a long way to try to provide the financial resources to people to get into the nursing profession and to try to expand the involvement of people in that profession. It is a very, very, very severe need that we see today, in some parts of the country more so than others, but it's starting to surface everywhere, and it really needs to attract the

attention of Congress and something that Congress needs to deal with.

Finally, I would like to make the comment about public and private financing of long-term care. Providers are as concerned as anyone about how we're going to pay for long-term care going forward. Medicare does not pay for nursing home care. It clearly does not. As good as some of the catastrophic proposals that just passed Congress are, they do not deal with the real catastrophic problem, and that is dealing with an extended stay in a nursing facility and payment for nursing home care.

Long-term care insurance is a bright spot in the future. It can indeed work, but we have to, I think, inform consumers that they need the product, that Medicare doesn't cover and assist the private sector in developing new products.

In the Medicaid Program we do have some severe needs if the program stays in place in the future; access to capital. Most of the nursing homes in this country are 20 and 30 years old. They are in need of renovation and, in many cases, total replacement. When we try to cut back on the Medicaid Program, it's been easier to cut back on the building repairs and maintenance than it has been to face the prospect of cutting back on nursing care itself.

We now have to put some dollars back and reinvest in keeping our facilities top-notch and first class. That's a severe challenge going forward, I know, at both the State and Federal level, but it's very important.

I think I'm out of time, and again, I thank you very much for the opportunity to testify.

Senator DURENBERGER. Thank you very much.

Our next witness is Gayle Kenvold.

GAYLE KENVOLD, EXECUTIVE VICE PRESIDENT, MINNESOTA ASSOCIATION OF HOMES FOR THE AGING

Ms. KENVOLD. Thank you, Senator. I'm here today speaking on behalf of the Minnesota Association of Homes for the Aging. Our members provide health care and housing and community-based services to about 40,000 persons throughout the State of Minnesota. The majority of our members are not-for-profit organizations sponsored by religious, fraternal, and governmental entities. I appreciate the opportunity to be here today, and I would like to thank you, Senator Durenberger, for your attention to health care issues.

Providers in Minnesota are in a unique position to speak to Federal initiatives in long-term care. Few, if any States, have embarked upon as aggressive a reform policy in long-term care as we have here in Minnesota. The changes that we have implemented since the early 1980's are too many to go into today, but as providers, we have moved into a new era of maximizing efficiency and productivity, while attempting to sustain what is widely acknowledged to be a very high standard of care throughout the industry. We have diversified, we have reorganized, we have joint-ventured, we have affiliated, and many of the results of all of this change are very positive.

The rate of growth in the nursing home portion of the State budget has been reduced to less than the rate of inflation. There

has been an explosion in the development of housing, much of it with a service component. Availability of home-based services has increased. Nursing home occupancy has declined even with tight controls on supply, and the evolution of the nursing home as a health care facility for those who are the oldest and/or the most frail and/or without family support has been hastened.

The sweeping changes at the State level have helped us identify some of the concerns that remain for us at the Federal level, and I would like to briefly highlight those for you.

We remain heavily dependent upon Medicaid, and we're, therefore, particularily vulnerable to any changes in Federal spending—even more so in Minnesota because of our equalization of rates law. All but a handful of the homes in this State participate in Medicaid, and on average, 65 to 70 percent of the persons in our facilities rely upon Medicaid to meet the costs of their care.

The legislation that was recently enacted by Congress and referenced in earlier testimony is definitely a step in the right direction in terms of improving quality in our long-term care facilities, but I would emphasize that it would be tragic to raise the expectations for improved outcomes unless States also assure that there will be the financial resources needed to achieve those higher objectives.

As other panelists mentioned, private sector initiatives, such as long-term care insurance, hold some hope for long-term care financing in the future, but I would agree that these initiatives are not likely to supplant the need for ongoing public support for long-term services.

Second, in regards to Medicare, it is not today a long-term program. That is certainly not new information for you, Senator, nor is it for providers across the Nation. It is new information for many older people who are seeking nursing home admission for the first time and discover that Medicare does not, it fact, cover 100 days of long-term care.

Barring structural change in the Medicare Program, in the short term older persons need to be clearly informed about the limitations of Medicare coverage in time to plan for financial alternatives.

Two years ago Minnesota required all Medicaid certified homes to also certify for Medicare. Our association opposed that legislation, not because we wanted to see older people denied an important benefit, but because it had been our experience, and continues to be, that the administrative costs and regulatory burdens associated with the Medicare Program tent to exceed the benefit to potential consumers.

Again, barring structural change in the Medicare Program, new initiatives should be aimed at assuring a uniform, consistent application of Medicare eligibility criteria at the level of the fiscal intermediary that's broad enough to be of real benefit to consumers. Given that reform, I'm convinced that providers will voluntarily participate in this program in greater numbers.

As a final note on Medicare, I also believe that the time has come for structural change related to long-term care. The concept of a "Medicare Part C" has merit, and I'm also of the opinion that some type of means testing for these benefits is probably inevitable.

Finally, I referred earlier to the evolution of the nursing home, and I would like to speak briefly to that in the context of what I call changing practice patterns. Providers report more frequent admissions, shorter lengths of stay and more complex care needs among their residents. Today we're being called upon increasingly to admit persons dependent on ventilators and respirators, persons requiring transfusions, and persons with AIDS. At the same time, we see demand for board and care diminishing.

From a social policy perspective, these are very positive changes. Long-term care facilities can provide a cost-effective alternative for some complex, subacute care that was formerly only available in the hospital. It is also certainly positive that home-based services and assisted living have provided viable alternatives for persons who otherwise would have sought nursing home placement; but a fundamental problem remains. Financing for the range of long-term care services is fragmented at best, and the regulatory requirements of the variety of programs that fund long-term care create a lack of flexibility in our ability to respond.

In addition, nursing home reimbursement systems in most States, even those with case mix reimbursement like our own, probably cannot address the additional costs of subacute care.

Finally, in answer to Bob Kane's challenge to long-term care providers to make a difference, I believe that's possible, and I believe that we do. I would add that in order to make that possible we must be recognized as partners in, and not exclusively the object of, social policy reform.

Thank you, Senator.

Senator DURENBERGER. Well said. Thank you.

Pat Adams, Dakota County.

STATEMENT OF PAT ADAMS, DIRECTOR, DAKOTA COUNTY PUBLIC NURSING SERVICE

Ms. ADAMS. Senator Durenberger, it is my privilege to speak to you today during the Senate hearing about long-term care issues from the perspective if metropolitan counties. The counties in Minnesota have a long history of financially supporting home health, human services and in-home support services for chronically ill, disabled and elderly persons. These services are an important component of a long-term care system that often have no other funding source than county tax dollars.

Minnesota can be proud of the services and options available to low-income disabled persons, frail elderly and medically fragile children through the medical assistance program. Through the use of Federal waivers, we use MA dollars more creatively. These persons who are at high risk for hospitalization or nursing home placement can receive expanded community-based services to enable them to remain independent in the community.

These waivered services are managed by public health nursing and social services staff in each county. Unfortunately, persons who are not eligible for medical assistance do not have access to the same level of services provided without assuming the full cost for those services. For most of those individuals and families, the

cost of long-term care services are prohibitive, and they are not included, generally, in their health insurance benefit package.

Traditionally, the reimbursement systems for health care services pay only for those services which are provided in an institutional setting. A high priority is placed on acute and critical care services that required advanced medical technology and skills. The DRG system for early discharge encourages cost containment for acute care services, but makes little provision for the ongoing health care services for persons who are being discharged quicker and sicker.

Medicare, which does include intermittent home care benefits as an extended covered service, is moving to further regulate and restrict the eligibility for and scope of those home health services. Consequently, persons whose lives are being saved by our advanced technology are often being discharged to their own homes without the needed follow-up of in-home support and home health services. These are conflicting public policies, in light of the changing national demographics of an aging and increasingly chronically ill population.

It is time for the Federal Government to take the initiative to define the Nation's system for health care, which must address and fund not only the acute and catastrophic health needs of our citizens, but also the long-term care needs that most chronically ill persons of all ages have.

At present, our system of care is based on medical necessity. Most persons in need of long-term care services are chronically ill and/or functionally dependent. They require ongoing rehabilitative and maintenance services to enable them to remain in the community. These kinds of services are usually not determined to be medically necessary, but are essential to help people maintain levels of maximum wellness. Through the provision of health maintenance and in-home support services to individuals and their families, health care crises are often minimized or avoided, thus reducing the cost of more expensive acute care services.

Because of the rapid development of our medical technology, persons of all ages are surviving longer, and this is creating a new demand for long-term care services for people who would probably not have survived in generations previous to this one.

We must support ways to creatively assist persons to receive the care they need in the least restrictive and most cost-effective setting. The development and financing of a comprehensive system of health services requires cooperative efforts between the private health insurance industry and Federal, State, and local government entities. The system for decision making regarding the appropriate level and site of care for an individual should be one that is managed at the local level and is community-based.

The use of institutions for the admission of health services should be used as an alternative to services provided in the community. Institutional care is a very necessary and positive part of the entire health system and should be reserved for those persons who cannot receive quality cost-effective health services delivered in a community system.

As Congress considers funding options for catastrophic illness and long-term care needs, I encourage you, Senator Durenberger,

and other legislators to incorporate eligibility concepts which broaden the definition of "medical necessity." Functional limitations of chronically ill children and adults must be recognized as legitimate health needs in order to make available options for the provision of community-based services which are incentives to delay or prevent institutional care.

Medical necessity must be acknowledged as one part of the continuum of health care needs of chronically ill, disabled, and aging persons, all of whom require varying degrees of acute, maintenance, and custodial care to enable them to live in the least restrictive and most cost-effective setting.

Thank you.

Senator DURENBERGER. Thank you very much. Adele, Adele has been working in the field of aging for 18 years, and she was a volunteer coordinator over at Ebenezer and has done a variety of things, including graduate work at the University of Minnesota in adult education. We're particularly pleased that you're here this week, and I understand that you lost your mother last week, and we certainly, all of us who know and respect you and your family, extend to you our deepest sympathies and welcome you here today.

STATEMENT OF ADELE MEHTA, CASE MANAGER, SENIOR COMMUNITY SERVICES

Ms. MEHTA. Thank you very much. Senator Durenberger, I very much appreciate this opportunity.

We, as a nation, face a tremendous challenge, a challenge unlike any we have faced before, a challenge that is as intricate and all pervasive as any we have yet faced in our history. As you have pointed out, the number and percentage of elderly are growing at an unprecedented rate. The elderly, particularly the "old old" comprise the age group with the fastest growth rate. The number of adults over 85 is growing 10 times faster than the nonelderly population, and of course, this is the group most in need of long-term care.

Currently, most of us, whether private citizens, workers in the field of aging or legislators, agree that helping people to remain in their own homes is generally more cost effective and more in keeping with the wishes of the elderly themselves. Yet, the vast majority of our tax dollars continue to go toward maintaining the elderly in nursing homes.

As the elderly population is exploding, we can no longer afford to allocate primary funding to nursing home care. Creative, flexible community-based in-home services must be funded if we are to meet the requirements both of cost consciousness and of human need. On a national level, nursing home expenditures increased by 82 percent between 1976 and 1980.

What is needed are some creative new approaches for providing more community-based services and for funding them. The Federal Government could leverage much of the funding for effective community-based long-term care by encouraging partnerships between various levels of government and community agencies.

Minnesota has many examples of this cooperation between government and the nonprofit sector, but I would like to share the ex-

perience of a program with which I am most familiar. Senior Community Services, a private nonprofit agency, coordinates four multipurpose senior centers, 19 community senior groups and low-income high-rise resident councils, as well as an innovative employment program for seniors. These programs were created for maintaining the well and near vulnerable elderly.

The fourth agency program, Senior Outreach, is a community-based counseling and case management program for the more frail, vulnerable elderly, the largely invisible elderly. Senior Outreach serves seniors 55 and older, regardless of income, throughout the suburban and rural areas of this county. We receive referrals from physicians, family, hospitals, nursing services, senior centers, community senior groups and potential clients themselves. Most of our clients tend to be frail, low-income women over the age of 75, living alone, and most in need of outside support to maintain themselves in the community.

As a Senior Outreach case manager and like our other case managers, I meet with the elderly in their own homes. In this way I have the opportunity of learning firsthand about their needs. I may meet family or neighbors. I know firsthand whether heating is adequate and whether they have food. Together, the older person and I look at a wide variety of needs, such as medical needs: Perhaps a physician or supplemental Medicare insurance or an HMO is needed.

Financial need: Perhaps the older person qualifies for Energy Assistance, Medical Assistance or an alternative care grant. Social needs: The person might welcome a regular visit from a volunteer or need some respite care for an ill spouse in order to go out to the senior center.

The need of activities of daily living: Possibly help is needed with a bath or cooking a meal. Nutritional needs: The person may be receiving Meals On Wheels when a meal with others at a senior nutritional site is more appropriate, or help is needed with grocery shopping.

Psychological needs: Perhaps the person is being battered and needs a shelter and special counseling, or the older person may be grieving the loss of a job or a friend of their own health. Transportation needs: Perhaps a ride to the doctor is needed for a person in a wheelchair, or possibly rides are needed for visits with a spouse in a nursing home.

HOUSING NEEDS

The person's house may need major repairs that a housing grant would cover, or possibly the older adult is thinking of selling the home and needs to know what alternatives are available.

After assessing all of the older person's needs, and this may take one visit or several more visits, we together come up with an overall plan that is most appropriate and most cost-effective for that person's needs and wishes. As a case manager, I then work to involve as broad a support network for the older person as possible. Support networks usually include informal support such as friends, neighbors, and family members, as well as formal supports with physicians, pre-admission screening, adult day-care and others.

I would like to sum up by saying, since my time is up, that I think two of the reasons that the program is innovative and can be very helpful in terms of looking at some possibilities for community-based care is that, first of all, while Senior Outreach clients are frail, low-income elderly over 75, over 93 percent of them remained independent in the community, which compares to 17 percent institutionalized who are over 75, with an additional 18 percent considered severely impaired noninstitutionalized; and second, I believe that senior Outreach is an example of what government and community-based nonprofit agencies can do by working cooperatively to provide both, services and funding. A Title III grant began the program, and since then, funding has come from the United Way, many of the municipalities served, a county contract, foundation grants and many contributions from clients, their families and the community.

Thank you very much.

Senator DURENBERGER. Thank you very much.

STATEMENT OF SALLY KNUTSON, MEDICAL PERSONNEL POOL

Ms. KNUTSON. Thanks for coming home, Senator Durenberger, to talk with us about this significant issue.

I am a nurse and have been for several years and have been involved in home health care and long-term care for at least 10 years, and I can say that it's much more positive to provide hands-on care than to deal with the struggles of finances and the provision of adequate staff.

I want to share a brief case study, which I think will support what the rest of my panel have suggested. There are HMO's and social HMO's and the traditional third-party payers. There are copayments and deductibles, and there is private pay; and the elderly population's response to all of this is to say, "I have Medicare, and they will pay for everthing"; this is a cultural response.

I was invited to one of my client's home a week ago to meet with the client and his family to discuss the bills that he owed our company. I went, and we spent an hour and had a nice visit. Mr. G is 78, and Mrs. G. is 81, and has become too frail to remain in their single dwelling home, this is in a local nursing home. He, of course, remained at home. This is the financial situation that they are dealing with in order to receive long-term care.

It costs Mr. G. about $41,000 a year to receive 24-hour live in service from our company. His wife is in one of the local nursing homes and is billed approximately $28,000 a year for that service. The transportation for Mr. G. to get from his home to visit his wife daily will cost about $3,500 a year; and in addition to maintain his household, because he's too frail to manage his home, the cost will be about $10,000 a year. So for $82,300 they can receive long-term care.

I left their home last week and had an appointment with my personal financial planner, and it was a very important meeting, because I have 25 years of a career to plan for my long-term care and for my family. It is overwhelming to think about and to deal with the potential expenditures of $82,000 a year for perhaps 2, 5, or even 10 years. That's overwhelming.

The two questions that we were supposed to respond to today are challenging. The most significant problems facing the delivery of long-term care, I have six responses. I would say that the most significant problem is the inadequate reimbursement for services provided; second, inadequate number of trained health care and social service personnel to provide the services; third, the growing regulation at the Federal and State level, thus increasing the operating costs to the providers; fourth, current extensive budget deficit at the Federal level; fifth, the constant increase in demand for services, all of your blue and red and white graphs indicated very clearly; and sixth, our society's attitude about the "value," in quotes, of the persons requiring long-term care.

What should Congress do to address some of the problems? Shifting Medicare dollars from the acute setting to home care and long-term care services is very important, and this means changing Medicare eligibility criteria; the appropriate funding for the growth of the social HMO's, I believe that they are a real significant piece of our future; evaluating a national health care system for all segments of the population; decreasing regulation by continuing to transfer health care delivery to the private sector; and requesting the participation of the private sector in the creation and implementation of a long-term care plan.

We must come together, the private and the public sector, strengthen our relationships and create a future for all of our elderly.

Thank you.

Senator DURENBERGER. Thank you very much. Just one question of clarification, Sally, as long as you used the figures and the example, the $82,000 example, if we just take the $41,000 component, which you obviously understand since it's your charges and your services, were a person qualified for Medicare reimbursement, for example, because it was medically necessary, how much of that $41,000 would be reimbursed by Medicare?

Ms. KNUTSON. Very little. The Medicare criteria indicate that the individual must be improving significantly or deteriorating, so perhaps anywhere from 5 to 10 skilled nursing visits at approximately $50 a visit would be covered. Perhaps 10 to 12 nursing aide visits at $35 a visit would be covered and maybe some physical therapy or occupational therapy, social service; so a very small portion of the $41,000 would be covered.

Senator DURENBERGER. The problem there, as Harold pointed out to us a little earlier, is that we currently reimburse only 21 days, and now we're going to extend that to 45; so using an annual example, I have cut back with what Medicare will reimburse. But for the 21 days, assuming they are qualified, are you adequately or inadequately reimbursed for your services for those——

Ms. KNUTSON. It's inadequate reimbursement, not so much for the provider as for the client, because Medicare will only cover intermittent visits or service, which means 1 to 3 hours maximum per day for the 21 days as it relates to home care.

Senator DURENBERGER. Right.

Ms. KNUTSON. So that is, most often, inadequate for the patient unless they have a very strong support system, informal support system, around them.

Senator DURENBERGER. All right. Well, I thank all of you very much for being here today and for your statements, which will be made a part of our record.

Our final panel, the people who are undertaking to find ways to help us to finance, are Peter Falkman, who is the Director of Life Scope at Northwestern National Life Insurance Co.; Lloyd Pearson, Human Services at the Honeywell Corp.; John Drozdal, Product Administration at Blue Cross/Blue Shield; Charlaine Tolkien, H.R. Generalist Services at IDS Financial Services, whatever that is; Ron Johnson, who is the President of Senior Care Services.

Thank you, ladies and gentlemen for being here.

You may now proceed to summarize your statements. I am certainly grateful to you, as I am sure other members of the committee will be, for your willingness to participate.

We will begin this final panel with Mr. Peter Falkman of Northwestern National Life.

STATEMENT OF PETER FALKMAN, DIRECTOR, LIFESCOPE, NORTHWESTERN NATIONAL LIFE INSURANCE

Mr. FALKMAN. Thank you, Senator Durenberger. On behalf of Northwestern National Life, I'm pleased to be here today to talk a little bit about some of the things that we're doing as a company and some of the things that we feel Congress could be doing or ought to be taking a close look at in order for us to facilitate some of the things that we're doing.

Presently, Northwestern National Life is the tenth largest provider of group benefits and has launched an ambitious program to take a look at health care benefits, as well as financial and social benefits, throughout one's entire lifetime. What we're interested in doing is putting together a funding system, insurance products, social service products, to cover people throughout their entire working years, as well as into retirement.

In order to do this, we're going to need help. We're going to need help from a number of different people. We're going to need help from nursing homes. We're going to need help from hospitals. We're going to need help from employers. We're also going to need help from the public sector.

In answering the two questions that you posed to each of the panel members, I would like to address each of those as follows. First of all, employers out there that we have talked to are aware of and, to some extent, acknowledge the problem of retiree health care benefits. They also know that in terms of tax laws, it, by and large, discourages employers from prefunding retiree health care plans.

Employers who have provided health care coverage to retirees and their dependents are quite likely in the future, because of FASB recommendations—Financial Accounting Standards Boards—to reflect the full liability for both retirement health care benefits that they are currently obligated to. This could amount to as high as $2 trillion for American corporations, $2 trillion that would come, essentially, from the profit line.

Furthermore, employers continue to struggle with the uncertainty of Government actions, including the tax treatment of reim-

bursed accounts, as well as Senator Kennedy's proposal to extend health care coverage to all workers.

Furthermore, it appears that individuals increasingly are going to have to bear more responsibility and are going to have to be encouraged to save money, to select benefits at their place of employment and to plan more realistically for the future. Unfortunately, the 1986 tax bill sent the wrong signal as far as savings by limiting the most popular tax-deferred savings plans that were out there.

Insurers across the country need to be more creative in designing products to meet the needs of both employees, as well as employers. Insurance companies' insurance products must respond to a society that is growing older, a work force that is becoming increasingly more mobile and a world marketplace where 10.9 percent of the U.S. gross national product is spent on health care, compared to 7.4 percent in Japan.

I'm particularily pleased to talk a little bit about the kinds of products that we have available at Northwestern National Life in 1988. Essentially, we'll be dealing with three products. There will be a long-term care product that will emphasize long-term care in the second quarter of 1988. Along with that will be a retiree medical product, which will, essentially, focus in on preventive gerontology and wellness and include prescriptive drugs; and a third product that will, essentially, take a look at lifestyles of people who are 50 to 64 and people who are 65 on out to become more—to have the individual become more aware of the relationship between the lifestyle that they are leading and, conceivably, some future health care costs and/or institutionalizations that may be required because of their present lifestyle.

We are also stressing three things in the LifeScope initiative. One is flexible benefits. Increasingly, you're going to see more and more employers offering benefits for people in their working years who are concerned with child care, as well as offer benefits for people who are close to retirement; but we're going to need help in the sense of Congress passing legislation that will allow flexible benefits to be more creatively offered by the the employer.

Second, you're going to see more and more health care in terms of long-term care being delivered in a managed care setting. Managed care is essentially going to include wellness programs. It's going to include geriatric assessment. It's going to include a number of different products throughout one's entire lifetime.

Third, there is going to be a requirement or a feeling, if you will, or need for fund accumulation. More and more people in their 30's and their 40's are going to have to save, and employers and employees are going to have to be encouraged to prefund retiree health care, including long-term care.

Finally, we looked to the Federal Government for leadership. The Health and Human Services Task Force on Long-Term Care has developed a number of recommendations, and in our mind, the most important is the need for the U.S. Department of Treasury to formalize its position regarding tax treatment of long-term care.

We should also treat employee health plans and give that the same tax-preferred status as contributions to pensions now enjoy. We also hope that Congress will reverse the action of the 1986 tax

bill and encourage more long-term savings by individuals through IRA's, 401(K) plans and similar programs.

Again, I thank you on behalf of Northwestern National Life and myself for being allowed to participate in this testimony. Thank you.

Senator DURENBERGER. Thank you, Peter, very much. Lloyd?

STATEMENT OF LLOYD PEARSON, HUMAN SERVICES, HONEYWELL CORP.

Mr. PEARSON. Thank you, Senator. It's a privilege to be here. I'm forced to say at the beginning that Honeywell, being viewed in some circles as a leader in the area we're here to deal with today, suggests to me that real solutions may be a long way down the road.

We have, however, for nearly a decade, exhibited a real interest in older workers and older people issues in general. In 1979 we established the Honeywell Retiree Volunteer Project, which enables some 700 to 800 retirees to engage in community service regularly.

We have conducted a number of surveys over the years. First, in 1983, a retirement planning survey of people over 40 and a survey of retirees to identify the special concerns of older employees and older people generally. In 1985, as a result of that survey we established an older workers league, which provides a forum for older workers to identify issues peculiar to their age, and provides a resource for management to assist in responding to and dealing with those issues.

In 1986, we conducted a survey of a number of employees, a large number of employees, on work/family issues. Certainly, out of that we identified elder care as one such issue.

In 1987, we established a multilevel management task force to deal with some of the issues identified there, and today are implementing a number of their recommendations. These include increasing management sensitivity and understanding of the issues employees face, and developing training programs to enhance the employees' ability to manage some of those work/family conflicts.

We have a broad employee assistance program with counselors in most major facilities. We have established a dialog locally with the area agency on aging to ensure that our counselors are aware of the services available from the Federal Government through those agencies.

We've had a flexible benefits program since 1986, which offers, among other things, the pretax health care and dependent care set-asides.

We have Flex-Time and have offered that since 1982. Interestingly, the Health Care Reimbursement Account and the Dependent Care Reimbursement Account, which are available to 46,000 salaried employees across the country, are not used to any great extent. For example, the Dependent Care option is used by only 3 percent of our employees and most of those, it appears, use it for child care rather than elder care.

We ask why, and I think it's because for many, particularly the people in the lower income brackets, the tax credit offers a better deal. The dependency requirement creates a problem for many.

"Use it or lose it" is a concern, and the overall complexity in making their decisions enters into it.

Heath care, about 17 percent of eligible employees take advantage of that set-aside, but again, the figure might be larger except for the dependency requirement and again, the use it or lose it mandate. We're told that the maximum set-aside, which is now $2,400, may be reduced to $750. If that happens, it's likely that Honeywell will discontinue this benefit. This could happen in either case because of the nominal use of the dependent care benefit and certainly in the event of a reduced level of benefit to employees under the option.

Our surveys have disclosed that almost half of all employees over 45 live in extended care households. That's with adult children or aging parents. Twenty-five percent have concerns with problems of their aging parents in the household. Elderly concerns seem to be equal with child care concerns. It's just that they are at the other end of the age spectrum as far as employees are concerned.

Employees whose productivity is being impacted by elder care concerns, generally, are the more senior employees, the more experienced and higher paid employees; so there is a real employer incentive to deal with this problem. The demographics you showed earlier, Senator, certainly support that concern.

So the recommendations would be, of course, do not reduce tax credit programs; do provide real tax incentives, both to employers and employees, to encourage development of creative solutions to the problem and the financing of these solutions. Try to enable employees to set aside money to better deal with their future problems, perhaps by taking advantage of the improved insurance programs that surely are coming; and to make them more affordable.

Certainly, and I'll close with this, recent deletion, for most people, of the deduction for IRA contributions would appear to have been a step in the wrong direction.

Thank you.

Senator DURENBERGER. Thank you very much. John? John Drozdal, again, is with Blue Cross/Blue Shield.

STATEMENT OF JOHN DROZDAL, PRODUCT ADMINISTRATION, BLUE CROSS/BLUE SHIELD

Mr. DROZDAL. Senator Durenberger, thank you very much. It's a pleasure to be here this morning.

For over 50 years Blue Cross/Blue Shield of Minnesota has responded to the needs of Minnesota by developing innovative coverage plans. Our new long-term care product, Future Gold, was designed to provide Minnesotans with the four benefits most sought after by consumers when they looked to buy long-term care insurance.

In addition to offering an extremely comprehensive home health care benefit, Future Gold is the only plan currently offered in Minnesota that can be purchased on a paid-up basis, it's the first to allow the individual to purchase additional coverage to keep up with the rising cost of long-term care expenses, and it's the only plan at the present time that does not require a prior hospital stay to qualify for benefits.

I find it useful to divide the problem of long-term care really into two parts, and both have been addressed very well today. One of the hazards of speaking at the end of a program is that you run the risk of people already saying what you wanted to say.

Nevertheless, the two parts of the problem, as I see it, are the quality delivery of long-term care services to those most in need and then the financing of those long-term care services. Now, I would like to confine my remarks to the second part. That is, how do we pay for long-term care services?

It's already been established that there are basically two major sources of funding. One is out-of-pocket. The private individual has to pay a large portion of the costs, and then once they are impoverished, the Medicaid Program picks up the expenses. Now, that's a trend that really can't continue for very much longer. The burden on the private individual and the burden on the Federal and State governments to continue funding the Medicaid Program at its present level is just too great to all concerned.

Now, the Task Force on Long-Term Care Health Policies has recommended that private long-term care insurance is a reasonable solution. I concur with this recommendation and offer a couple of observations. One is that long-term care insurance is really a long-term solution. Just as one doesn't purchase homeowner's insurance when their house is on fire, one certainly can't purchase long-term care insurance once in a nursing home or once they require home health care services.

Second, there are a number of barriers to offering long-term care insurance. One of the primary barriers that has already been mentioned is that most people think they are covered. Most people believe, and this has been borne out by a Gallop survey as well as a survey done by the American Association of Retired Persons, that Medicare is going to pay for long-term care services. That is simply not true.

Most people also believe that their health care coverage will pay for long-term health care costs. That's also not true. What is covered is, primarily, rehabilitative care on a short-term basis in a skilled nursing facility and that's it.

So the burden on the insurance industry is to help educate people that there is a major area for which they are not covered, namely, the risk of long-term care services; but I think that there are a couple of things that Congress can do that can really help promote the development of long-term care insurance, and I have two very specific recommendations.

One is that Congress enact legislation to modify Section 125 of the Internal Revenue Code to permit the use of flexible spending account dollars for the purchase of long-term care policies, both on a lifetime pay and a paid-up basis. This provision will encourage individuals to purchase long-term care while they are actively employed, at a time when they are most insurable and when the policies are most affordable.

The second recommendation is that there could be changes in Medicaid eligibility requirements such that the Medicaid spend-down requirement could be waived for all individuals who exhaust lifetime maximum benefits under a qualifying long-term care plan.

This provision would enable individuals who purchase a long-term care policy to meet certain benefit standards to be protected from that catastrophic event of having to spend down their assets in order to qualify for Medicaid.

This provision would place the Medicaid Program in the position of a stop-loss insurer. It would remove the need for Medicaid to start picking up coverage right at the very beginning of a long-term care stay and would spread the cost of care to the private sector, that is, to insurance carriers who are writing this sort of coverage.

For example, if an individual had a long-term care policy that paid up to $80 a day and carried a lifetime maximum of $144,000, that would provide coverage for 1,800 days in a nursing home. The way this recommendation would work is that in the event that the individual exhausted the benefits under the policy, Medicaid coverage would kick in after the $144,000 maximum is reached.

This approach would really provide substantial savings to the Medicaid Program, and at the same time, would offer an incentive for the purchase of long-term care insurance because people would have the assurance of knowing that they have purchased insurance which will enable them to protect their assets, and avoid Medicaid spend down requirements.

Those are the two specific recommendations that I would like to make, and again, I thank you very much for the opportunity to speak this morning on this issue.

Senator DURENBERGER. And I thank you, John.

First, the modification of Section 125 is a bill that I have already introduced. I get discouraged that nothing has happened to it when I hear Lloyd say that only 3 percent of the 46,000 employees seem to be interested in it, but then I hear that one of the reasons they are not interested in it is that they think that in other ways they are being covered or that there are other provisions for dependent care.

But it strikes me that almost all of the 46,000 Honeywell employees should be interested in being able to buy long-term care protection while they are working, and the younger they are, I take it, the less they would have to spend out of the overall flex benefit account for that, and they could buy more of something else that was of more immediate benefit.

Mr. PEARSON. Then I think they would be interestered in that.

Senator DURENBERGER. OK. Charlaine?

STATEMENT OF CHARLAINE TOLKIEN, H.R. GENERALIST SERVICES, IDS FINANCIAL SERVICES CORP.

Ms. TOLKIEN. Thank you, Senator. What I would like to do this morning is to take an opportunity to offer some additional perspective to what Lloyd has offered from Honeywell, sort of an employer's viewpoint to this issue and how it does impact us.

We at IDS Financial Services are a very service intensive business, and therefore, our ability to hire and maintain a very productive work force will maintain our future success. We have identified and seen that there often are conflicts between work responsibilities and family responsibility, and to address that, established a

task force in early 1987 to really study this and make recommendations to our senior management.

Part of their study process included a survey of employees, I think, similar to what Honeywell has done. We were very surprised at the results of the survey. We did not expect elder care to emerge as a concern because our work force is fairly young, the majority being under 35 years of age. Yet, we found that over one-third of all of our employees are concerned about caring for an aging parent or other relative, and over two-thirds of our employees over age 45 showed this concern; and as pointed out earlier, again, it's significantly more women than men showing this concern, as women are the traditional care givers in our society.

About 5 percent of our employees do have primary care responsibility for another adult, and this is usually a parent, based on our survey, and involves anywhere from 10 to 50 percent of their time that they spend away from work. We do believe that based on just demographics alone, as you pointed out, that this percentage is going to increase dramatically in coming years, and will increase the stress and conflict that our employees experience between work and family responsibilities.

At IDS we believe that the primary responsibility for family matters does rest with the employee. We also know that many people will view—increasingly, people view their employer as a resource during times of family need or family crisis. This is really a new role for employers, and one that we certainly take very seriously.

We attribute, in part, this change in roles to the advent of employee assistance programs and more and more involvement by employers in offering resources like that to their employees, but to us, the bottom line is that it makes good business sense for us to do this, and we really see this as a business issue.

I just want to tell you briefly about what we have done. Our approach really now is to focus on our employees as care givers, to understand that they have these responsibilities outside of their work responsibilities, and to do what we can to support them in this role. We have taken a few steps I'll share with you.

The first is we have extended our personnel leave of absence. It's an unpaid leave of absence program, but we have extended it up to 1 full year, and that's a recent change for us; but in this past year, 1987, several employees have taken advantage of this opportunity to care for an aging parent or a disabled spouse.

We have education programs during noon on things like "You and Your Aging Parent," on "Choosing a Nursing Home," so that we can provide information, bring in community resources, improve the access to resources for our employees. We do have a referral information on long-term care available through our employee assistance program and advertise that fact.

American Express, which is our parent corporation, now offers the opportunity for employees to purchase long-term care insurance, and we are planning to extend this opportunity for our employees at IDS here in Minneapolis. This long-term care insurance does allow employees to protect their assets in the future and make the kind of decisions now about their financial future security that have been certainly advocated by many people that have testified today. We're excited about that possibility and find it very consist-

ent with our philosophy of empowering our employees to take care of themselves and make the decisions for their own lives.

We also have brought together government, business, social services, and education leaders in Minneapolis to establish a downtown Minneapolis work and family resource center. We're conducting a pilot of this concept during the first quarter of 1988 and plan to be open for business by September of this year.

This center will bring together a variety of resources, community resources and family related resources including care for the elderly, long-term care, that kind of thing, and make these very accessible to people who are employed in the downtown community, people from as small as two-person offices to the very large employers like IDS that have resources on our own.

So we are, again, very excited about this possibility as a way to support our employees. So as you can see, we certainly recognize the issue of aging and long-term care as it does affect our employees. We do take this issue seriously and are committed to continue working to assure that our employees have access to support and help that they need.

Again, we appreciate—while we have no specific recommendations for Congress, we do appreciate your thoughtful initiative in this matter and look for your support in the future on it. Thank you.

Senator DURENBERGER. Thank you very much.

Now, Ron, I have to give you a little more of an introduction because Senior Care could be anything, I guess, Senior Care Services, Inc. Ron Johnson has been in the long-term care insurance business for almost 15 years now. Nobody, I don't think, knew that, so probably, this is a welcome time in your life; but Senior Care Services, Inc., which is Ron's business, markets the Sentry Group long-term care insurance policy on a national basis. It's specifically one of the policies that is approved here in Minnesota.

So since everybody else is sort of identified by where they work or something like that, I though I should give you a little more of an introduction. Thank you for being here.

STATEMENT OF RON JOHNSON, PRESIDENT, SENIOR CARE SERVICES

Mr. JOHNSON. Thank you, Senator Durenberger. We have, in fact, marketed long-term care and nursing home insurance for a number of years dating back to 1973, and policyholders of the various group plans that we have marketed through the years have received approximately $4 million in claims, most of them here in Minnesota.

Since 1981, our programs, have all been group insurance for a variety of group sponsors, employers, association groups and so forth. During the period of the time from 1981 to 1985, we put about 2,000 people into the various groups, and as of the present time, there have been approximately $1,600,000 paid in claims on about 60 people.

I did a little analysis of the claims list, and the nursing home across the street has received about $172,000 in claims on behalf of six people. Many of them were residents of these buildings, so

there has been the existence of coverage over the years. It's just that it hasn't been broadly available. It hasn't been widely known that people could protect themselves against nursing home expenses.

The largest claim that we have paid was on a policy purchased about 4 years ago. The person was in their 80's at that point. They bought a $50-a-day benefit, and they have received, at this point, over $50,000. Their condition for the confinement was a stroke, but we have other claims that we are currently paying, again, across the street, that include Alzheimer's, diseases of the central nervous system, and miscellaneous diseases of aging.

The current Sentry program that we offer is approved in the State of Minnesota. It's the only group plan that I'm aware of. It's available to a wide variety of group sponsors, including associations, employers, and any other appropriate group sponsor within the State of Minnesota. Unique to Sentry is that the same product is available with the same benefits and the same pricing structure outside of Minnesota and is currently available in 42 States.

We find that as we market on a national basis, there is one very interesting problem that is emerging, and I would like to highlight that as my recommendation for Federal action. The U.S. Department of Health and Human Services task force report that you have on the table stated that private financing of long-term care through insurance to demonstrate its potential will be most successful through the workplace. This approach will promote market growth and reduce the age of purchase. The greatest benefit from this approach will result in marketing to groups which have multistate or national constituencies.

The problem is that States are acting to regulate long-term care insurance in different ways, and a group policy which meets one State's standards may not be legal in a neighboring State. A review of some of the State-specific legislation is on pages 277 to 306 of the task force report. While some States exempt employer/employee groups from their new regulations, they make no such exemptions for other group sponsors, such as trade or professional associations, membership organizations such as the American Bar Association, the American Health Care Association or for that matter, AARP.

Senior Care Services markets the Sentry plan on a national basis, meets the standards set in Minnesota, and is approved for sale to Minnesota residents. It also exceeds the standards established by the National Association of Insurance Commissioners in their Long-Term Care Insurance Model Act. Yet, we cannot offer the same policy to eligible group members who reside in Oregon, Washington, Kansas, or North Dakota. These States have new regulations, which, while not necessarily stricter than Minnesota's, are different enough from each other's so that the policy cannot meet all of their requirements and Minnesota's as well.

Many other States are now working on their own unique regulations as well. Wisconsin, taking a more logical approach, recognizes this problem for group insurance and permits its residents to be insured in this group plan, which does not comply with Wisconsin's rules if fewer than 25 percent of the insureds in the plan are Wisconsin residents.

From a Federal standpoint, if States were encouraged to exempt group insurance from the specific codes, which are contradictory in nature, it would go a long ways toward facilitating broad marketing, because while an employer group may fit, a trade or professional association group may very well not.

Senator DURENBERGER. Well, very good. I thank all of you and all of the witnesses here today for their testimony. Thank you members of this panel, and thank everyone who came to be part of this meeting.

I'll stick around for a few minutes in case anybody has anything specific they would like to talk about, but for now, the official meeting of the Special Committee on Aging is concluded.

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